

MISSOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

DEPARTMENT OF PUBLIC HEALTH AND WELFARE

63-041922

STATE FILE NUMBER

DO NOT WRITE
ON THIS STUB

AMENDED

Registration District No. 318 Primary Registration District No. 1003 Registrar's No. 10225

FILED OCT 17 1963

1. PLACE OF DEATH a. COUNTY		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Mo. b. COUNTY	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN ST. LOUIS, MO.		c. CITY OR TOWN St. Louis	
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION ST. LOUIS CITY HOSP.#1		d. STREET ADDRESS (If outside, give location) 2223 Hickory	

3. NAME OF DECEASED (Type or print) First MIDDLE LAST LULA PITTMAN	4. DATE OF DEATH Month 10 Day 10 Year 63
---	---

5. SEX Female	6. COLOR OR RACE Negro	7. Married <input type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input checked="" type="checkbox"/> Divorced <input type="checkbox"/>	8. DATE OF BIRTH Sept, 11 '05	9. AGE (last birthday) 58	IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HR
------------------	---------------------------	---	----------------------------------	------------------------------	---	----------------

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Maid	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (City and state or country) Webb, Miss	12. CITIZEN OF WHAT COUNTRY U. S. A
---	-----------------------------------	--	--

13a. FATHER'S NAME Casle Robinson	13b. MOTHER'S MAIDEN NAME Carrie A. Dickson	14. NAME OF HUSBAND OR WIFE Deceased
--------------------------------------	--	---

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) No	16. SOCIAL SECURITY NO. No	17. INFORMANT Esther Durr 2223 Hickory
---	-------------------------------	---

18. CAUSE OF DEATH (Enter only one cause per line) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Pulmonary Edema	INTERVAL BETWEEN ONSET AND DEATH
---	----------------------------------

Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b) Congestive Heart Failure DUE TO (c) Hypertensive Cardiovascular Disease	
---	--

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) 1) Parathyroid Hyperplasia 2) Lobar Pneumonia	PART III. If deceased was female was there a pregnancy in last 90 days. <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Unknown
--	---

19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	20a. ACCIDENT <input type="checkbox"/> SUICIDE <input type="checkbox"/> HOMICIDE <input type="checkbox"/>	20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in PART I or PART II of item 18.) 44 3X
---	---	---

20c. TIME OF INJURY Hour a.m. p.m. Month, Day, Year	
--	--

20d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	20e. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	20f. CITY, TOWN, OR LOCATION 10/8/63 10/10/63 10/10/63	COUNTY	STATE
--	--	---	--------	-------

21. I attended the deceased from Death occurred at 7:30PM.	to 10/10/63 and last saw her alive on 10/10/63
---	--

22a. SIGNATURE Richard L. Phillips M.D.	22b. ADDRESS 1515 LAFAYETTE AVE.	22c. DATE SIGNED 10/10/63
--	-------------------------------------	------------------------------

23a. BURIAL CREMATION, REMOVAL (Specify) Removal	23b. DATE Oct 17, 1963	23c. NAME OF CEMETERY OR CREMATORY Greenwood Cemetery	23d. LOCATION (City, town, or county) St. Louis County	(State) Mo.
---	---------------------------	--	---	----------------

24. FUNERAL DIRECTOR O.B. Koonce	25. DATE RECD. BY LOCAL REG. OCT 14 1963	26. REGISTRAR'S SIGNATURE Loan Smith M.D.
-------------------------------------	---	--

(Licensed Embalmer's Statement on Reverse Side)

USE BLACK INK
OR
TYPEWRITER RIBBON

AMENDMENTS ON THIS RECORD ARE AS FOLLOWS

INSTEAD OF

SHOULD READ

DOCUMENT

BY AFFIDAVIT OF

DATE AMENDED

ITEM NO.

VS 300
Rev. 4/59

1

2

3

4

5

6

7

8

9

10

11

12

13

75-0

75

8541 11-5712

7/10/10

ST. LOUIS, MO.

ST. LOUIS, MO.

ED 01 01

MAINTENANCE

ALUM

Reference

7/10/10

7/10/10

7/10/10

STATEMENT BY LICENSED EMBALMER

I hereby certify that the body whose name is recorded on the reverse side of this certificate was embalmed by me,

or by _____, Student Embalmer No. _____

working under my personal supervision.

Student _____

Signature of Student Embalmer

Signed

Lawrence Adams

Licensed Embalmer No.

4755

ED/8/01 P. O. Address

1221 Grand

ED/01/01

ED/01/01

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to comply with the above constitutes grounds for revocation of license).

If embalmed by a STUDENT, he also shall sign in his OWN handwriting.

If this body is not embalmed, fact should be so stated above.

ED/01/01